GEORGIA DEPARTMENT OF COMMUNITY HEALTH

GEORGIA MEDICAID FEE-FOR-SERVICE
PARENTERAL NUTRITION PRODUCTS PA SUMMARY

Preferred	Non-Preferred
n/a	Kabiven (amino acid 3.3%, dextrose 9.8%/lipid 3.9%/electrolytes 0.7%) Perikabiven (amino acid 2.4%/dextrose 6.8%/lipid 3.5%/electrolytes 0.5%)

LENGTH OF AUTHORIZATION: 1 year

PA CRITERIA:

- Approvable for members 18 years of age or older when oral or enteral nutrition is not possible, insufficient or contraindicated

AND

- Member's parenteral nutrition needs are not able to be obtained through administration of individual products that contain amino acid, dextrose, lipid and/or electrolytes.

EXCEPTIONS:

- Exceptions to these conditions of coverage are considered through the prior authorization process.
- The Prior Authorization process may be initiated by calling **OptumRx at 1-866-525-5827.**

PREFERRED DRUG LIST:

- For online access to the Preferred Drug List (PDL), please go to http://dch.georgia.gov/preferred-drug-lists.

PA and APPEAL PROCESS:

- For online access to the PA process, please go to www.dch.georgia.gov/prior-authorization-process-and-criteria and click on Prior Authorization (PA) Request Process Guide.

QUANTITY LEVEL LIMITATIONS:

- For online access to the current Quantity Level Limits (QLL), please go to www.mmis.georgia.gov/portal, highlight Provider Information and click on Provider Manuals. Scroll to the page with Pharmacy Services and select that manual.